

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

## CERTIFICATE OF DEATH

04948

Reg. Dist. No. 110

### 1. PLACE OF DEATH:

County Baltimore  
City or town Hurlock  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Hurlock  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Edgar F. Bradley

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Mar 46 1871 5. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 74 Months 1 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ind  
(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business \_\_\_\_\_

12. Name William F. Bradley

13. Birthplace Ind

14. Maiden name Emily Hopkins

15. Birthplace Caroline Co. Md.

16. Informant Mrs Edgar F. Bradley

Address Hurlock

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof May 11 1946  
(month) (day) (year)

Cemetery or crematory Cemetery

Location New Hurlock

18. Funeral director F. B. Willey & Son

Address Hurlock

19. May 31 - 1945 Chas W Hastings  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 - 1945 at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 44 to May 45

and that I last saw him alive on May 45

Immediate cause of death exhaustion

DURATION

Due to Paralysis Agitante 2 yrs +

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William C. Harrison MD

Address Hurlock Md Date signed 5/13/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, USING UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

JUN 1 1945

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04949

Reg. Dist. No. 115

### 1. PLACE OF DEATH:

County Dorchester  
City or town Fishing Creek  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: home  
Slay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Slay in this community (yrs., or mos., or days) Life

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester  
City or town Fishing Creek Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. near P.M. Office  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR no

### 3. (a) FULL NAME

Raymond William Brinson Jr.

### 3. (b) Social Security Number

MS

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife no

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 23 - 1945

8. AGE: Years \_\_\_\_\_ Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. 50 min.

9. Birthplace Fishing Creek, Md.  
(Town, county, and state)

10. Usual occupation infant - new born

11. Industry or business \_\_\_\_\_

12. Name Raymond William Brinson

13. Birthplace Tampa, Fla.

14. Maiden name Lula Meade Creighton

15. Birthplace Fishing Creek, Md.

16. Informant Lula M. Brinson

Address Fishing Creek, Md.

17. Burial Date thereof May 24 - 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Haven Memorial Cemetery

Location Fishing Creek, Md.

18. Funeral director Myford Creighton

Address Fishing Creek, Md.

19. May 24 19 45 James W. Meade  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 45 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 19 45 to May 23 19 45 and that I last saw him alive on May 23 19 45

Immediate cause of death Premature Birth DURATION \_\_\_\_\_  
Post Utero Gest about 4 months

Due to Premature Rupture Membranes

Due to Other Cause unknown  
evidently spontaneous

Other conditions none

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James W. Meade M.D. or other \_\_\_\_\_  
Fishing Creek, Md. Date signed May 24 19 45

Address \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 28 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

## CERTIFICATE OF DEATH

Reg. Dist. No. 04950 115

1. PLACE OF DEATH: Dorchester  
 County.....  
 City or town.....Fishing Creek  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....entire life  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants, give residence of mother)  
 State.....Maryland County.....Dorchester  
 City or town.....Fishing Creek  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....none  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
Mary Eliza Creighton

3. (b) Social Security Number  
none

4. Sex.....Female  
 5. Color or race.....white  
 6.(a) Single, married, widowed, or divorced.....Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....June 7-1865  
 6.(c) If alive, give age..... years

8. AGE: Years.....79 Months.....11 Days.....27 If less than one day..... hrs. .... min.

9. Birthplace.....Fishing Creek  
 (Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business.....George E. Creighton

12. Name.....George E. Creighton

13. Birthplace.....Dor Co.

14. Maiden name.....Anna Eliza Wallace

15. Birthplace.....Dor Co.

16. Informant.....Miss Nora J. Creighton

Address.....Fishing Creek

17. Burial.....5731-45

(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory.....Hopewell M.E.

Location.....Fishing Creek

18. Funeral director.....Samuel R. Shuman

Address.....Cambridge, Md.

19. May 30 1955.....James W. Meace

(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 29 19..... at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 19..... to May 29 19..... and that I last saw her alive on May 29 19.....

Immediate cause of death.....Chronic hepatitis  
 DURATION.....10 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....James W. Meace M.D.

Address.....Fishing Creek, Md. M. D. or other

Date signed.....May 30 1955

RECEIVED  
JUN 1 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

04951  
Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County SevierCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SevierCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 231 Cedar St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Erene Cornish

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Geo. Cornish7. Birth date of deceased (mo., day, yr.) 7 7 1896 6.(c) If alive, give age 50 years8. AGE: Years 49 Months 7 Days 7 If less than one day hrs. min.9. Birthplace Maryland - Balto  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business none12. Name Unknown13. Birthplace Maryland14. Maiden name Unknown15. Birthplace Unknown16. Informant Geo. CornishAddress 231 Cedar St.17. Bethel Cemetery Date thereof May 29  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bethel A.M.E. CemeteryLocation Cambridge18. Funeral director Rev. J. H. BannumAddress 201 Wash. St. Camb. Ind.19. May 26 19 45 John MacG. M.D.  
(Date registered by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 45, at 10:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 19 45, to May 24 19 45.and that I last saw him alive on May 24 19 45.Immediate cause of death Cerebral Hemorrhage DURATION 5 daysDue to Senile Hypertension 1944Due to Senile Hypertension 1944Other conditions Dehydration 19 daysYoung Hemorrhage 6 days  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carole M. O'Leary M. D. or otherAddress On Cedar St Date signed 5-28-45

RECEIVED  
MAY 29 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

## CERTIFICATE OF DEATH

04952  
Reg. Dist. No. 110

## 1. PLACE OF DEATH:

County DorchesterCity or town Salestown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 48 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dorchester County MdCity or town Near Salestown, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife S. Vesta Ellis7. Birth date of deceased (mo., day, yr.) Dec. 20, 1862 6. (c) If alive, give age 66 years8. AGE: Years 82 Months 5 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Dorchester Md  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Joseph Ellis13. Birthplace Del14. Maiden name Eliza J. Hearn15. Birthplace Del.16. Informant Vesta EllisAddress Seaford, Del. R.D.17. (Burial, cremation, or removal, Which?) Burial Date thereof 5-27-1945  
(month) (day) (year)Cemetery or crematory SalestownLocation Gravenor Bros18. Funeral director Sharpton, MdAddress Seaford, Del.19. 5/27 19 45 L. L. Hastings  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 45 at 6:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 19 43 to May 24 19 45  
and that I last saw him alive on April 29 19 45Immediate cause of death Chronic Kurocarditis DURATION 10 yrs?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions arteriosclerosis ?

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Howard L. Higgins M. D. or otherAddress Seaford, Del. Date signed 5/26/45

RECEIVED  
JUN 19 1945  
BUREAU

RECEIVED  
JUN 19 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

Reg. Dist. No. 04953, 15

1. PLACE OF DEATH: Dorchester  
 County.....  
 City or town.....Fishing Creek  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....entire life  
 Hospital, institution, or street address where death occurred:.....home  
 How long in hospital or institution?.....none

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Maryland County.....Dorchester  
 City or town.....Fishing Creek  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....near Post Office  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
Edna H. Flowers

3. (b) Social Security Number  
no

4. Sex.....Female 5. Color or race.....white 6. (a) Single, married, widowed, or divorced.....Married

6. (b) Name of husband or wife.....Thomas H. Flowers

6. (c) If alive, give age.....50 years

7. Birth date of deceased (mo., day, yr.).....July 19 - 1895

8. AGE: Years.....49 Months.....9 Days.....22 If less than one day..... hrs. .... min.

9. Birthplace.....Fishing Creek  
 (Town, county and state)

10. Usual occupation.....Housewife

11. Industry or business.....Geo. Wm Hall

12. Name.....hloc co

13. Birthplace.....Susan E. Tolley

14. Maiden name.....hloc co

15. Birthplace.....hloc co

16. Informant.....Mr Allen R. Adams

Address.....Cambridge, Md.

17. Burial.....May 13-1945

(Burial, cremation, or removal. Which?)..... Date thereof..... (month) (day) (year)

Cemetery or crematory.....Hoosier Memorial

Location.....Fishing Creek

18. Funeral director.....Kenneth R. Thomas

Address.....Cambridge, Md

19. May 12 1945.....James W. Meade  
 (Date rec'd by registrar) LOCAL Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 11 1945 at.....7:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....Dec 27 1944 to.....May 11 1945

and that I last saw him.....alive on.....May 11 1945

Immediate cause of death.....Carcinoma of breast

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....no

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....James W. Meade M.D.  
 Address.....Fishing Creek, Md Date signed.....May 12/45

RECEIVED  
MAY 15 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04954

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County..... Dorchester  
City or town..... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... X

Hospital, institution, or street address where death occurred:

Barracks near Factory C., -Phillips  
Packing Co.

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Dorchester

City or town..... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Park Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Samuel Gadsden

## 3. (b) Social Security Number

4. Sex..... male  
5. Color or race..... colored  
6. (a) Single, married, widowed, or divorced..... single

6. (b) Name of husband or wife..... X

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... April 15, 1921

8. AGE: Years..... 24 Months..... 1 Days..... 8  
If less than one day..... hrs. .... min.

9. Birthplace..... South Carolina  
(Town, county, and state)

10. Usual occupation..... Laborer11. Industry or business..... General12. Name..... Lonnie Gadsden13. Birthplace..... South Carolina14. Maiden name..... May Gadsden15. Birthplace..... South Carolina16. Informant..... Records of Phillips Packing CoAddress..... Cambridge, Md.

17. Burial Date thereof..... 5-30-45  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Mount CityLocation..... Cambridge, Md.18. Funeral director..... Louis H. BapstienAddress..... Cambridge Maryland19. May 25-45 Registrar..... John H. J. J.

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 23..... 1945..... at..... 11 P.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... X..... 19..... to..... X..... 19.....and that I last saw h..... X..... alive on..... X..... 19.....

Immediate cause of death.....

Pistol Shot wounds of  
Chest and Abdomen

## DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... homicide..... Date of..... May 23/45.....Where did injury occur?..... Cambridge - Dor...... Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... Workers barracksMeans of injury..... pistol..... Injured at work?..... noSignature..... J. H. Shriner, Dep. Med. Exam.Address..... Cambridge, Md...... Date signed..... May 24/45

UNITED STATES DEPARTMENT OF JUSTICE

GENERAL INVESTIGATIVE DIVISION

RECEIVED  
MAY 31 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1360

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County... Dorchester  
 City or town... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles H. Smith

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Alma Peters

7. Birth date of deceased (mo., day, yr.) April 7, 1867 6. (c) If alive, give age 75 years

8. AGE: Years 78 Months 1 Days 15 If less than one day  
 .....hrs. ....min.

9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Former Farmer

## 11. Industry or business

12. Name unknown13. Birthplace Germany14. Maiden name Louise Poloff15. Birthplace Germany16. Informant Mrs. Char. H. SmithAddress Cambridge Md.17. Buried Date thereof 5/24/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory East New MarketLocation East New Market Md18. Funeral director Reineth R. ShumanAddress Cambridge, Md.19. May 24 19 45 John M. J. M.

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 106 Kennelburn ave.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 45 at 11:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20 19 45 to May 22 19 45and that I last saw him alive on May 20 19 45Immediate cause of death arteriosclerosis DURATIONCardio-vascular ?Renal Disease

Due to

Due to

Other conditions Cerebral evidence Oct. 1944

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eldridge H. WolfordAddress Cambridge Md Date signed 5-23-45

RECEIVED  
MAY 25 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

## CERTIFICATE OF DEATH

04956

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

134 Mill St.How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 134 Mill St.

(If rural, give LOCATION)

2.(a) If veteran, name war -

## 3. (a) FULL NAME

M. Warren Hooper

## 3. (b) Social Security Number

-

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Annie L. Jones6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) March 30, 1872.

## 8. AGE:

7314

.....hrs. ....min.

9. Birthplace Hoopers Island, Dor. Co., Md.  
(Town, county, and state)10. Usual occupation Retired

## 11. Industry or business

Merchant12. Name Matthew T. Hooper13. Birthplace Maryland.14. Maiden name Julian A. Meekins15. Birthplace Maryland16. Informant Mrs. Annie J. HooperAddress 134 Mill St., Cambridge, Md.17. Burial Date thereof May 7, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cambridge CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte Funeral ServiceAddress Cambridge, Maryland.19. May 7 - 19 45 John Mace Jr. M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 19 45 at 8: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Approx. 2.5 19 45 to May 4 19 45  
and that I last saw him alive on May 1 19 45

Immediate cause of death

Myocardial Infarction

DURATION

1 yr.

Due to

Pneumonia

Due to

Arteriosclerosissecond year

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till to the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr. H. Shrim M.D.  
Address Cambridge, Md. Date signed May 7/45

RECEIVED  
MAY 8 1945  
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(13-6)

04957

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 days  
 Hospital, institution, or street address where death occurred:  
Cambridge Maryland Hospital, Inc.  
 How long in hospital or institution? 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 12 Pine Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Augusta Matthews

## 3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6. (a) Single, married, widowed, or divorced widowed

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1st 1883

8. AGE: Years 62 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

6. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation House work

## 11. Industry or business

12. Name Matt Pinder

13. Birthplace Maryland

14. Maiden name Mary Johnson

15. Birthplace Maryland

16. Informant Hattie Matthews

Address East new market

17. Buried Date thereof May 17 1945  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location East new market

413 Wilboughby

18. Funeral director East new market

Address East new market

19. May 18 19 45 John MacFarland  
 (Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 45 at 5:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 45 to May 14 19 45 and that I last saw her alive on May 14 19 45

Immediate cause of death Uremia

Due to Chronic nephritis

Due to Chronic cardiac malnutrition

Other conditions Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Albert E. Byrnes M.D.  
 Address 37 Race St., Cambridge Md. M. D. or other  
 Date signed 5-15-45

## DURATION

2 day1 yr5 yrs.

RECEIVED

RECEIVED

RECEIVED  
MAY 18 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

04958

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge RFD # 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Home RFD # 2

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Rural--Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD # 2

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John R. Mills, Jr.

## 3. (b) Social Security Number

-

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

-

6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) March 17, 1906

## 8. AGE:

Years

39

Months

2

Days

1

If less than one day

hrs. min.

9. Birthplace Church Creek, Dor. Co., Md.

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

Dirt

FATHER

12. Name John R. Mills13. Birthplace Maryland

MOTHER

14. Maiden name Katie Hall15. Birthplace Maryland16. Informant Mrs. Katie MillsAddress RFD # 2, Cambridge, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 21, 1945

(month) (day) (year)

Cemetery or crematory Greenlawn CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceCambridge, Maryland.

Address

19. May 21, 1945

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1945 at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 X to 19 Xand that I last saw X alive on X 19 X

Immediate cause of death

Lightning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of May 18/45Where did injury occur? Dorchester (City or town) Dor. (County) Md. (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury Lightning Injured at work? yes

23. SIGNATURE

J. H. Shriver, Dep. Med. Exam.

M. D. or other

Address Cambridge, Md. Date signed May 24/45

RECEIVED

MAY 25 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04959

Reg. Dist. No. 64 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cambridge-Hayward HospitalHow long in hospital or institution? (3 weeks) 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Hurlock - Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Near Maddele's Corner  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Parker

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Levin Parker

7. Birth date of

deceased (mo., day, yr.)

April 27, 19116. (c) If alive, give age 39 years

8. AGE:

Years

34

Months

0

Days

6

It less than one day

.....hrs. ....min.

9. Birthplace Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

FATHER

12. Name

Thomas Adams

13. Birthplace

Dorchester County, Maryland

MOTHER

14. Maiden name

Emma Pinkett

15. Birthplace

Dorchester County, Maryland

16. Informant

Levin Parker

Address

Hurlock, Maryland, C.F.D.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 6, 1945  
(month) (day) (year)

Cemetery or crematory

Washington Cemetery

Location

Near Hurlock, Maryland

18. Funeral director

J. J. Frompton & Son

Address

Federalsburg, Maryland

19.

May 5 1945  
(Date signed by registrar)S. S. Frompton  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1945 to May 3 1945and that I last saw her alive on May 2 1945

Immediate cause of death

Probable Brain abscess

DURATION

2 wks.

Due to

Meningococcus meningitis4 wks.

Due to

Other conditions

Syphilis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William C. Harrison MD

M. D. or other

Address

Hurlock Md.Date signed 5/5/45

RECEIVED  
MAY 12 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1520

## CERTIFICATE OF DEATH

Reg. Dist. No. ~~110~~ 119

## 1. PLACE OF DEATH:

County DorchesterCity or town Wingate  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

WingateHow long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Wingate  
(If outside city or town limits, write RURAL and give nearest town)Street No. Wingate  
(If rural, give LOCATION)2.(a) If veteran, name war -

## 3. (a) FULL NAME

Barbara Ann Parks

## 3. (b) Social Security Number

-

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

(Infant)

## 7. Birth date of deceased (mo., day, yr.)

Oct. 11, 1944.6. (c) If alive, give age - years

## 8. AGE:

Years -Months 6Days 23

If less than one day

- hrs. - min.

## 9. Birthplace

Cambridge, Dor. Co., Md.

(Town, county, and state)

## 10. Usual occupation

-

## 11. Industry or business

-

## FATHER

## 12. Name

Asbury George Parks

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Rosalie Willey

## 15. Birthplace

Maryland

## 16. Informant

Mrs. A. G. Parks

## Address

Wingate, Maryland.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 7, 1945.  
(month) (day) (year)

## Cemetery or crematory

Bloodsworth Cemetery

## Location

Wingate, Maryland

## 18. Funeral director

LeCompte's Funeral Service

## Address

Cambridge, Md.

## 19. May 6, 45

(Date rec'd by registrar)

William D. Pitchett  
seal Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 419 45 at 6-45 A

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

- 19 - to - 19 -and that I last saw him - alive on - 19 -

## Immediate cause of death

## DURATION

Congenital Malformation  
of Heart

## Due to

## Other conditions

Prone to pneumonia  
weeks ago

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. -

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of -

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

J. H. Shriver, Dep. Med Exam  
M. D. or otherAddress Cambridge, Md. Date signed May 7, 45

RM 1737  
MAY 14 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04961

## CERTIFICATE OF DEATH

Reg. Dist. No. 110

## 1. PLACE OF DEATH:

County DorchesterCity or town Williamsburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, Institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Williamsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Stephen Pinder

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Mary Pinder7. Birth date of deceased (mo., day, yr.) About 1880

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day

About 65--- hrs. - min.9. Birthplace Dorchester County, Maryland  
(Town, county, and state)10. Usual occupation Day laborer11. Industry or business Same12. Name Ernest Pinder13. Birthplace Dorchester County, Maryland14. Maiden name Minta15. Birthplace Dorchester County, Maryland16. Informant Nettie LakeAddress Williamsburg, Maryland17. Burial  
(Burial, cremation, or removal. Which?) Date thereof May 29 1945  
(month) (day) (year)Cemetery or crematory Washington CemeteryLocation Near Hublock, Maryland18. Funeral director J. J. Frampton and SonAddress Federalburg, Maryland19. May 29 - 45  
(Date rec'd by registrar)Chas W. Hedding  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 8 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1945 to May 1945, and that I last saw him alive on May 26 1945.Immediate cause of death Chronic myocardial degenerationDue to arteriosclerosisDue to old age

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. J. Harrison MDAddress Hublock, Md. Date signed 5/29/45

M. D. or other

RECEIVED  
JUN 6 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Nr. Hoopers Island  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Drowned In Chesapeake Bay

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State North CarolinaCity or town Rural--Gates  
(If outside city or town limits, write RURAL and give nearest town)Street No. RFD # 2  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

William Thomas Pittman

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Jan. 2, 1912.

## 8. AGE:

Years

Months

Days

If less than one day

33415

\_\_\_\_\_hrs. \_\_\_\_\_min.

9. Birthplace Gates, RFD # 2, North Carolina  
(Town, county, and state)10. Usual occupation Mariner11. Industry or business United States Navy

FATHER

## 12. Name

Unknown

## 13. Birthplace

MOTHER

## 14. Maiden name

Altah Pittman

## 15. Birthplace

Unknown16. Informant J. E. Agar, Pharmacist MateAddress Chimcoteague, Virginia

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 7, 1945.  
(month) (day) (year)Cemetery or crematory Gates CemeteryLocation Gates, North Carolina18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. June 2, 1945  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1945 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
and that I last saw him X alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

DURATION

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of May 17/45Where did injury occur? Chesapeake Bay  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Off a U.S. BoatMeans of injury drowning Injured at work? Yes

23. SIGNATURE

Address Cambridge, Md. Date signed May 24/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

RECEIVED  
JUN 6 1945  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

## CERTIFICATE OF DEATH

04963

Reg. Dist. No. 116

1. PLACE OF DEATH:  
County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 Years  
Hospital, institution, or street address where death occurred:  
325 Henry St.,  
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 325 Henry St.  
(If rural, give LOCATION)  
2(a) If veteran, name war -

3. (a) FULL NAME  
Sarah Adams Seward

3. (b) Social Security Number  
-

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife George H. Adams  
(Deceased) 6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1867.

8. AGE: Years 78 Months 2 Days 20 If less than one day - hrs. - min.

9. Birthplace Taylor's Island, Dor. Co., Md.  
(Town, county, and state)

10. Usual occupation None  
11

11. Industry or business

12. Name Josiah Moore

13. Birthplace Maryland

14. Maiden name Sarah E. Moore

15. Birthplace Maryland.

16. Informant Mrs. Arnold E. Elsey

Address 325 Henry St., Cambridge, Md.

17. Burial Date thereof May 3, 1945.  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cambridge Cemetery

Location Cambridge Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. May 3 - 45 John MacG. Med. Registrar  
(Date reported by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1945 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16, 1945 to May 1, 1945  
and that I last saw him alive on May 1, 1945

Immediate cause of death Myocardial Failure

Due to Insanitation

Due to Senility

Other conditions Fracture Right Hip

Due to Accidental Fall  
(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results -  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following no  
Accident, suicide, or homicide Accident Date of February 16, 1945

Where did injury occur? Henry Street, Cambridge, Dorchester Co., Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) On sidewalk

Means of injury Accidental Fall Injured at work? -

23. SIGNATURE John MacG. Med. M. D. or other -

Address Cambridge Md Date signed 5/2/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HANKS

RECEIVED  
MAY 5 1945  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH



Reg. Dist. No. 111

### 1. PLACE OF DEATH:

County Dorchester  
City or town Secretary  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Secretary  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

George B. Stone

### 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) aug 21 1862 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 80 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace New York  
(Town, county, and state)

10. Usual occupation sign

11. Industry or business \_\_\_\_\_

12. Name Edgar Geo Stone

13. Birthplace N. Y.

14. Maiden name Elsie F. Schluif

15. Birthplace N. Y.

16. Informant H. R. Stone

Address Secretary

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 16 1945  
(month) (day) (year)

Cemetery or crematory Cemetery

Location East New Market

18. Funeral director F. B. Willoughby

Address East New Market

19. (Date rec'd by registrar) \_\_\_\_\_ Registrar \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 45 at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 18 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 18 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Coronary Arteriosclerosis ?

Due to Arteriosclerosis ?

Due to \_\_\_\_\_

Other conditions Gangrene - left foot 2 wks

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. K. Shivers, Dep. Med. Exam. M. D. or other \_\_\_\_\_

Address Cambridge, Md. Date signed May 15 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED  
JUL 17 1945  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04965  
Reg. Dist. No. 112

## 1. PLACE OF DEATH:

County... Worcester  
City or town... Vienna  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John Theodore Vane  
4. Sex... Male 5. Color or race... white 6. (a) Single, married, widowed, or divorced... Married

8. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.)... Mar 9<sup>th</sup> 1866 8. (c) If alive, give age... years

8. AGE: Years... 79 Months... 3 Days... 6 If less than one day... hrs. ... min.

9. Birthplace... Ind  
(Town, county, and state)

10. Usual occupation... Retired

11. Industry or business

12. Name... Samuel Peyton Vane13. Birthplace... Ind14. Maiden name... Katherine Carroll15. Birthplace... Ind16. Informant... Mrs John B. VaneAddress... Vienna17. Burial Date throat... May 17 1945

(Burial, cremation, or removal) (Which?) (month) (day) (year)

Cemetery or crematory... CemeteryLocation... Vienna18. Funeral director... F.B. HilleburghAddress... East New Market19. May 17 45 19. 45 Elizabeth D. Biegl

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town... (If outside city or town limits, write RURAL and give nearest town)

Street No... (If rural, give LOCATION)

2. (a) If veteran, name war...

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 15 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 1945, to May 1945 and that I last saw him alive on May 13 1945

Immediate cause of death

Chronic myocardial  
dilatation  
arteriosclerosis

Due to...

Due to...

Other conditions... Chronic Colitis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... William C. Harrison MDAddress... Harlock Md. M. D. or otherDate signed... 5/17/45

DURATION

5 yrs +  
5 yrs +

10 yrs +

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED  
MAY 21 1945  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County... Dorchester  
 City or town... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... month  
 Hospital, institution, or street address where death occurred:  
Barracks on Edgewood Ave.  
 How long in hospital or institution?..... X

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Dorchester  
 City or town... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Edgewood Ave. barracks  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

George Ware

## 3. (b) Social Security Number

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife..... X  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) August 12, 1900  
 8. AGE: Years 44 Months 9 Days 18 If less than one day X hrs. X min.

9. Birthplace... Georgia  
 (Town, county, and state)  
 10. Usual occupation... Laborer  
 11. Industry or business... Canning House  
 12. Name..... X  
 13. Birthplace.....  
 14. Maiden name... Maggie Ware  
 15. Birthplace... Georgia

16. Informant... Records, Phillips Packing, Co.  
 Address... Cambridge, Md.

17. Burial Date thereof... 6-5-45  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory... Cemetery  
 Location... James City, Florida  
 18. Funeral director... John H. Byrnes  
 Address... Cambridge Md  
 19. June 2- 1945 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 30 19 45 at 10-20P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 ..... X ..... 19..... to ..... X ..... 19.....  
 and that I last saw h. X alive on ..... X ..... 19.....

Immediate cause of death... Haemorrhage  
 DURATION 5 min.

Due to... Stab wound in left side of neck.

Due to.....  
 Other conditions... X

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... homicide Date of... May 30/45  
 Where did injury occur?... Cambridge, Dor. Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) outside barracks  
 Means of injury Knife Injured at work? no

23. SIGNATURE... J. B. Shivers Dr. Med. Exam.  
 M. D. or other  
 Address... Cambridge, Md. Date signed... May 31/45

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

NAME OF MINISTER

DATE OF INTERMENT

RECEIVED  
JUN 4 1900  
U.S. DEPT. OF HEALTH



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

4967

Reg. Dist. No. 110

1. PLACE OF DEATH: Dorchester  
County.....  
City or town..... Near Salestown Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 5 years  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md County..... Dorchester  
City or town..... Near Salestown Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Elijah H. Wheedleton

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife..... Sara E.  
7. Birth date of deceased (mo., day, yr.) Jan 27 1871 6. (c) If alive, give age 54 years  
8. AGE: Years 74 Months 3 Days 19 If less than one day  
..... hrs. .... min.

9. Birthplace..... Preston Carolina Md  
(Town, county, and state)  
10. Usual occupation..... Farmer

11. Industry or business  
12. Name..... William Wheedleton  
13. Birthplace..... Md  
14. Maiden name..... Mary A. Griffith  
15. Birthplace..... Md

16. Informant..... William L. Wheedleton  
Address..... Seaford Del. R.D.

17. (Burial, cremation, or removal, which?) Burial Date thereof..... 5-18-1945  
(month) (day) (year)  
Cemetery or crematory..... Salestown

Location..... Gravemore Bros  
18. Funeral director..... Sharptown Md

Address.....  
19. 5-18 19. 45 B. L. Hastings  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5/16 19. 45 at 1-30 P.M.  
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
May 7, 1945 to May 16, 1945  
and that I last saw him alive on May 16, 1945  
Immediate cause of death..... diabetic mellitus  
DURATION  
Unknown  
Due to.....  
Due to.....  
Other conditions..... Arteriosclerosis Unknown  
(Include pregnancy within 8 months of death)

Major findings of operations.....  
Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....  
Means of Injury..... Injured at work?

23. SIGNATURE..... Metzger M.D.  
Address..... Bridgeville, Del. Date signed..... 5/19/45  
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 19 1945  
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

04968

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cambury Route 3  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Legation  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Cambury Md Route 3  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

Ernest Frederick Wilson

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

—

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

October 7 1944

8. AGE:

Years

Months

Days

If less than one day

728

hrs.

min.

9. Birthplace

Cambury Md Route 3  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Ernest Wilson

13. Birthplace

Cambury Md

14. Maiden name

Ada Banks

15. Birthplace

Church Creek Md

16. Informant

Ada Wilson

Address

Cambury Route 3 Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 8 1945  
(month) (day) (year)

Cemetery or crematory

Reck neck

Location

Reck

18. Funeral director

Lewis H. Basman

Address

Cambury Md

19.

(Date rec'd by registrar)

May 5 1945  
Dr. John Macfarland  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 51945 at 6:00 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 211945 to May 51945

and that I last saw him alive on

May 41945

Immediate cause of death

Bronchopneumonia  
(County)

DURATION

15 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carroll M. St. Clair, M.D.

M. D. or other

Address

900 Reck RdDate signed 5-5-45

RECEIVED STATE DEPARTMENT OF HEALTH

RECEIVED STATE DEPARTMENT OF HEALTH

RECEIVED  
MAY 8 1945  
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (938)

## CERTIFICATE OF DEATH

Reg. Dist. No. 04969

1. PLACE OF DEATH:  
 County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Cambridge Hospital  
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State md County Dorchester  
 City or town Centon md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION) no ✓  
 2.(a) If veteran, name war no

3. (a) FULL NAME James W. Waalford

3. (b) Social Security Number no

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Jennie Waalford  
Living 6. (c) If alive, give age 100 years  
 7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mayfield  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Same as above

12. Name Fortino Waalford

13. Birthplace Princess Anne

14. Maiden name Jennie Brice

15. Birthplace Princess Anne md

16. Informant Hylon Waalford

Address Salisbury md

17. Burial Date thereof May 20 - 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Centon

Location near Princess Anne md

18. Funeral director James H. Stewart

Address Salisbury md

19. May 20 19 45  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/1945 at 5:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/14/1945 to 5/17/1945 and that I last saw him alive on 5/17/1945

Immediate cause of death Myocardial failure

Due to arterio sclerosis  
coronary atherosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John Moore Jr M. D. or other

Address Chesapeake md Date signed 5/18/45

REC'D  
MAY 19 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

## CERTIFICATE OF DEATH

Reg. Dist. No. 04920

## 1. PLACE OF DEATH

County Dorchester  
 City or town Cambridge Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Smith  
 City or town Chesapeake  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Edgewood Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Woolford

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

Dec 11 1919

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Dec 11 1949

8. AGE:

Years

Months

Days

If less than one day

25519

hrs.

min.

9. Birthplace

Cambridge Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 301945 at 4:00 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 12 1945, to May 30 1945  
 and that I last saw him alive on May 27 1945

Immediate cause of death

Pulmonary Edema

DURATION

12 day

Due to

Chronic Myocarditis5 m

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. M. H. C.

M. D. or other

Address

Am. Red. St.Date signed 5-30-45

RECEIVED  
JUN 4 1945  
BUREAU V.B.